California Newborn Hearing Screening PROGRAM

[Enter Hospital Name Here]

NEWBORN HEARING SCREENING
Infant Reporting Form

INPATIENT SCREEN COMPLETED

IP Screening	RIGHT EAR		LEFT EAR	
DATE OF SCREENING				
TYPE OF SCREENING *(check one)*	☐ ABR ☐ DPOAE ☐ TEOAE	☐ ABR ☐ DPOAE ☐ TEOAE	☐ ABR ☐ DPOAE ☐ TEOAE	☐ ABR ☐ DPOAE ☐ TEOAE
RESULT *(check one)*	☐ PASS ☐ REFER	☐ PASS ☐ REFER	☐ PASS ☐ REFER	☐ PASS ☐ REFER

INPATIENT SCREEN NOT DONE (*fax completed form to HCC*)

☐ Transferred out to: _____ Hospital on (*date*): _____

☐ Missed; discharged without screen **(Complete Follow-Up section below)**

☐ Waived (Face Sheet not required) - ☐ NHSP Brochure given to parent

☐ Expired or physician determined screening not medically indicated (Face Sheet not required)

☐ Baby has atresia- ☐ Bilateral ☐ Unilateral: (check one) ☐ right ☐ left **(Complete Follow-Up section below)**

FOLLOW-UP FOR REFERS/MISSED *(fax completed form to HCC)*

☐ Parent/Legal Guardian information on face sheet verified/updated
Primary Language (Check One): ☐ English ☐ Spanish ☐ Other: _____

☐ Second contact information (relative or friend) is verified/updated on face sheet or below

Contact Name: _____ Phone: _____
Address: _____
City/Zip: _____

Primary Language (Check One): ☐ English ☐ Spanish ☐ Other: _____

☐ **Print Infant's Full/Legal Name:** _____

☐ NHSP Brochure given to parent (check one): ☐ Refer ☐ Refer to DX

☐ Follow-Up Appointment made and written on parent brochure:

APPOINTMENT: ☐ **OP** SCREEINING ☐ **DX** evaluation for **NICU** patients OR infants with **ATRESIA**
☐ **CCS REFERRAL MADE**
DATE: _____ **TIME:** _____ ☐ **COUNTY:** _____
PROVIDER: _____ **PHONE:** _____

☐ PCP who will see the Infant after discharge – Name: _____
Phone: _____

☐ Completed form **faxed *with hospital face sheet*** to the Northeastern & Central California Hearing Coordination Center, **fax No. 916-285-4690**. HCC contact phone No. 916-285-4680.

Addressograph

Patient Name: _____

Birth Date: _____

☐ **WBN** ☐ **NICU** Name of Birth Hospital if different

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